ESH is also of great value in the irrigation of drainage sites of established oro-facial-cervical infections or in Ludwig's angina.

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Facial expression in acute appendicitis

I read with interest the article by Mr Nicholas Odom (*Annals*, July 1982, vol. 64, p. 260). Of course acute appendicitis is not always an easy diagnosis to make. There are certain features which seem desirable if we are to make the diagnosis, such as acute abdominal pain, nausea or vomiting, some degree of pyrexia, and guarding in the right iliac fossa. However, many conditions can cause abdominal pain and nausea together with a slight pyrexia and in many instances there is tenderness, but the diagnosis of involuntary guarding is difficult. Hence there have been various tests to try to make this easier, such as the eliciting of rebound tenderness, Rovsing's sign, and pressing in the left iliac fossa and eliciting pain on the right side. In children many of us find the jump test of value, mainly in the exclusion of appendicitis; in other words, if a patient can jump up and down fairly vigorously without great discomfort then it is difficult to believe that an inflamed appendix is present. However, pain on jumping is not diagnostic of appendicitis.

In order to help in the diagnosis of a difficult case, a new sign should have the following characteristics. It should be simple to elicit and the objective features should be easy to understand and decisive. Examples of such signs would be eliciting of involuntary guarding and eliciting of pyrexia or, in other conditions, of fluctuation. It seems to me that facial expression in acute appendicitis probably does not show those features. For instance, Mr Odom describes the most striking features as being an 'aura of malaise' and pressure over the inflamed appendix causing nauseating pain rather than pain. These strike me as being imprecise in the extreme and no better (in fact probably worse) than the signs we already have at our disposal. I rather think Mr Odom gives his case away by saying it is difficult to describe the expression and also by saying that photographs of patients with the expression were unsatisfactory.

I think most of my fellow consultants will regard this new sign with healthy scepticim, but this may not be true of our junior staff, who may start taking the appendix out of any patient who wrinkles up his face slightly in response to abdominal examination!

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Rectal anastomosis with the EEA stapling instrument

Mr N J Dorricott and his colleagues (*Annals*, May 1982, vol. 64, p. 171) have presented their early experience with the EEA stapling instrument and give some useful technical hints. However, there are several points on which we would like to comment.

Firstly, it is misleading to compare their clinical and radiological leak rates (6% and 20% respectively) with Goligher's series of anterior resections *(1)* as they include all the sigmoid colectomy, left hemicolectomy, and total colectomy operations with their anterior resections; the clinical leak rate for their anterior resections is 11% and this should be the figure to compare with other series of anterior resections.

The second point is the need to check the anastomosis peroperatively, by insufflating air into the rectum with a Foley catheter, or postoperatively by radiological studies.

We have looked at the results of all the end-to-end stapled anastomoses performed during *anterior resection* in the Brighton region since the EEA stapler was first used in 1977. There were 78 patients — 39 male, 39 female, age range 41–93. All but one were elective operations; 62 (79%) were performed for carcinoma, 14 (18%) for diverticular disease, and 2 for lymphoma. The clinical leak rate was 8.9%; this compares favourably with other large series of staple-gun or hand-sewn anastomoses. The stricture rate at the site of anastomosis was 5.1% and these were managed with digital dilatation or dilatation with Hegar's dilators.

No peroperative or postoperative radiological studies were performed to investigate the anastomosis and we agree with Heald *(2)* that these are unnecessary and that the anastomosis may easily be damaged by an enema nozzle. We believe that the best way to check the anastomosis is by a bimanual digital examination. If the surgeon is unhappy about part of the anastomosis it can be reinforced with interrupted seromuscular sutures.

We agree that it is necessary to check carefully that two complete rings of bowel ('doughnuts') are retrieved; but it is interesting that of 15 cases in our series with one incomplete 'doughnut' in each case only in 5 was there a clinical leak. If an incomplete 'doughnut' was obtained the anastomosis was reinforced with sutures. In 8 cases a defunctioning colostomy was also performed.

We have seen no cases of late disruption of initially satisfactory stapled anastomoses *(3)*.

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1 Goligher JC. Recent trends in the practice of sphincter-saving excision for rectal cancer. Ann R Coll Surg Engl 1979;61:169–76.
2 Heald, RJ, Leicester RJ. The low stapled anastomosis. Dis Colon Rectum 1981;24:437–44.
3 Fielding JWL, Gourevitch A, Lee JR, Keighley MRB. Late disruption of initially satisfactory stapled anastomosis. Br Med J 1980;280:1418–9.